AGENDA

CONNECTICUT STATE BOARD OF CHIROPRACTIC EXAMINERS

Thursday, April 9, 2020, at 9:00 A.M.

Department of Public Health
410 Capitol Avenue, Hartford CT
Third Floor –Hearing Room

CALL TO ORDER

Minutes

Review of the minutes from January 16, 2020.

NEW BUSINESS

Memorandum of Decision – Luigi DiRubba, DC – Petition No. 2015-671

ADJOURN

The Department of Public Health is an equal opportunity provider and employer.

If you require aid/accommodation to participate fully and fairly, please contact the Public Health Hearing Office at 860-509-7566.

The following minutes are draft minutes which are subject to revision and which have not yet been adopted by the Board.

The **Connecticut State Board of Chiropractic Examiners** held a meeting at the Department of Health at 410 Capitol Avenue, Hartford, CT on January 16, 2020 in the third floor Hearing Room.

BOARD MEMBERS PRESENT:	Candito Carroccia, DC Gina Carucci, DC Karlos Boghosian, DC
BOARD MEMBERS ABSENT:	Sean Robotham, DC
ALSO PRESENT:	Jeffrey Kardys, Board Liaison Stacy Schulman, Hearing Officer

Dr. Carroccia called the meeting to order at 9:05 a.m.

I. MINUTES

Dr. Carucci made a motion, seconded by Dr. Boghosian, to approve the minutes from the November 21, 2019 meeting as edited. The motion passed.

II. NEW BUSINESS

Declaratory Ruling – FAA BasicMed Examination

Dr. Carucci made a motion, seconded by Dr. Boghosian to adopt the proposed Declaratory Ruling. The motion passed unanimously. The proposed ruling was signed by Dr. Carroccia. The proposed ruling will be sent to the parties for the opportunity to comment, and will then be provided to the Commissioner of the Department of Public Health for a final determination pursuant to Section 19a-14(f)(2) of the Connecticut General Statutes.

Annual Approval of Chiropractic Colleges/Universities

Dr. Boghosian made a motion, seconded by Dr. Carucci that pursuant to § 20-27(d) of the Connecticut General Statutes, to approve those colleges and universities that are accredited by the Council on Chiropractic Education as well as the Canadian Memorial Chiropractic College which the Board approved on April 26, 2018. The motion passed unanimously.

Review of mandatory continuing education topics

Dr. Boghosian made a motion, seconded by Dr. Carucci recommending that the mandatory continuing education topics include the following:

- 2.5 hours – Advances in clinical radiology in the practice of chiropractic
- 1 hour – Risk assessment and evaluation for prevention of falls
- 1 hour – Sexual boundaries and cultural sensitivities.

The motion passed unanimously.

Delegate to the Federation of Chiropractic Licensing Boards and the National Board of Chiropractic Examiners

Dr. Boghosian will this year's delegate on a motion made by Dr. Carucci, seconded by Dr. Carroccia

At a future meeting the Board would like an overview from the Department of Public Health regarding the probation monitoring process including the process for the selection of a practice monitors

III. ADDITIONAL BUSINESS

At a future meeting the Board would like an overview from the Department of Public Health regarding the probation monitoring process including the process for the selection of a practice monitors

IV. ADJOURN

The meeting was adjourned at 9:42 a.m. on motion by Dr. Carucci, seconded by Dr. Boghosian.

Respectfully submitted
Candito Carroccia, DC
Connecticut State Board of Chiropractic Examiners

STATE OF CONNECTICUT
BOARD OF CHIROPRACTIC EXAMINERS

Luigi DiRubba, D.C. **Petition No. 2015-671**
License No. 001055

MEMORANDUM OF DECISION

Procedural Background

On September 5, 2017, the Department of Public Health ("Department") issued a Statement of Charges ("Charges") against license number 001055 of Luigi DiRubba, D.C. ("Respondent"). Board Exhibit ("Bd. Ex.") 1. The Charges allege that Respondent's license is subject to disciplinary action under Connecticut General Statutes ("Statutes") § 20-29. Bd. Ex. 1.

On September 12, 2017, the Department sent the Charges and a Notice of Hearing regarding the Charges to Respondent, through his attorney, by certified mail, return receipt requested. Bd. Ex. 3. The Notice of Hearing directed Respondent to appear before the Board on November 9, 2017, for a hearing regarding the Charges. Bd. Ex. 3. On September 22, 2017, Respondent filed an Answer to the Charges. Bd. Ex. 2.

The Board held an administrative hearing on November 9, 2017, April 26, September 27 and November 1, 2018, and June 6, 2019, in accordance with § 4-166 et seq. of the Statutes and § 19a-9a-1 et seq. of the Regulations of Connecticut State Agencies ("Regulations"), to adjudicate Respondent's case. Respondent was represented by Attorney Heidi Cilano. Attorney Joelle Newton represented the Department. Both parties were given the opportunity to present evidence and argument on all issues and to conduct cross-examination. The record was closed on June 6, 2019.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record, the law, and the Board's specialized professional knowledge in evaluating the evidence. *Pet v. Department of Health Services,* 228 Conn. 651 (1994). To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.,* 605 F.Supp. 816 (Md. Tenn. 1985).

Allegations

1. In paragraph one of the Charges, the Department alleges that Respondent of Cheshire, Connecticut, is, and has been at all times referenced in the Charges, the holder of Connecticut chiropractic license number 001055. Bd. Ex. 1.

2. In paragraph two of the Charges, the Department alleges that in 2014 and 2015, Respondent provided multiple patients with chiropractic care including taking radiographs. Respondent's treatment of said patients failed to meet the standard of care in one or more of the following ways, including, but not limited to, that he:

    a. took clinically and/or medically unnecessary radiographs for three patients, including one patient who reported being seven weeks pregnant[1];
    b. took non-diagnostic, poor quality and/or substandard radiograph images for multiple patients;
    c. failed to establish, document and/or use appropriate radiographic protocol;
    d. used inappropriate radiographic technique guidelines by failing to identify whether the right or left side was imaged;
    e. took radiographs using inadequate collimation resulting in unnecessary radiation exposure to multiple patients;
    f. took radiographs and failed to shield and/or properly shield multiple patients; and/or,
    g. failed to maintain appropriate records. Bd. Ex. 1.

3. In paragraph three of the Charges, the Department alleges that the above described facts constitute grounds for disciplinary action pursuant to the Statutes, § 20-29. Bd. Ex. 1.

Findings of Fact

1. Respondent of Cheshire, Connecticut, is and has been at all times referenced in the Charges, the holder of Connecticut chiropractic license number 001055. Bd. Exs. 1, 2.

2. From approximately August 19, 2014 through September 10, 2014, Respondent provided chiropractic care to Patient A. Department Exhibit ("Dept. Ex.") 3.

3. From approximately September 9, 2014 through January 28, 2015, Respondent provided chiropractic care to Patient J.B. Dept. Ex. 4.

[1] After the Department rested, Respondent moved to dismiss allegation 2a. Tr. 4/26/18, pp. 191, 201. The Board granted the motion, finding that the Department failed to sustain its burden of proof that Respondent took clinically and/or medically unnecessary radiographs for three patients, including one patient who reported being seven weeks pregnant. Tr. 11/9/17, 66, 83, 99, 104, 109-111, 117, 121, 124, 133-134, Tr. 4/26/18, pp. 11, 13, 73-82, 90- 95, 106, 125-126, 196-197, 202; Dept. Exs. 3-5 and 8-10.

4. From approximately December 14, 2014 through February 3, 2015, Respondent provided chiropractic care to Patient J. Dept. Ex. 5.

5. From approximately January 17, 2015 through February 20, 2015, Respondent provided chiropractic care to Patient L. Dept. Ex. 6.

6. From approximately November 20, 2014 through March 4, 2015, Respondent provided chiropractic care to Patient M. Dept. Ex. 7.

7. From August 19, 2014 through March 4, 2015, Respondent took diagnostic quality radiograph images for patients A., J.B., J., L., and M. Dept. Exs. 3-12; Tr., 6/6/19, p. 26.

8. From August 19, 2014 through March 4, 2015, Respondent established, documented and used appropriate radiographic protocol for patients A., J.B., J., L., and M. Dept. Exs. 3-7.

9. From August 19, 2014 through March 4, 2015, Respondent used appropriate radiographic technique guidelines by identifying which side was imaged for patients A., J.B., J., L., and M. Dept. Exs. 3-7.

10. From August 19, 2014 through March 4, 2015, Respondent took radiographs using adequate collimation for patients A., J.B., J., L., and M. Dept. Exs. 3-7; Tr. 11/9/17, pp. 86, 147; Tr. 6/6/19, pp. 26-49.

11. From August 19, 2014 through March 4, 2015, Respondent took radiographs and properly shielded patients A., J.B., J., L., and M. Dept. Exs. 3-7; Tr. 6/6/19, pp. 26-49.

12. From August 19, 2014 through March 4, 2015, Respondent maintained appropriate records for patients A., J.B., J., L., and M. Dept. Exs. 3-7.

Discussion

Pursuant to § 20-29 of the Statutes, the Board "may take any of the actions set forth in § 19a-17[2] for . . . incompetent or negligent conduct in the practice of chiropractic . . . ." In this administrative proceeding, the Department bears the burden of proving its case by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board*, 309 Conn. 727, 739-740 (2013).

As discussed below, the Board finds that the Department met its burden of proof with respect to paragraph 1, but it failed to meet its burden of proof with respect to paragraphs 2b through 2g of the Charges.

[2] Section 19a-17 of the Statutes provides the types of disciplinary action the Board may impose based on conduct that occurred prior or subsequent to the issuance of a license upon finding the existence of good cause.

Paragraph 1 of the Charges is not in dispute. Respondent admits that he is from Cheshire, Connecticut and holds Connecticut chiropractic license No. 001055. Bd. Exs. 1,2.

With respect to paragraph 2 of the Charges, the evidence establishes that in 2014 and 2015, Respondent provided chiropractic care to multiple patients, including taking radiographs. Dept. Exs. 3-12. The Department failed to sustain its burden of proof that Respondent failed to meet the standard of care when he provided chiropractic care to said patients.

With respect to paragraph 2b of the Charges, the Board finds that a preponderance of the evidence fails to establish that Respondent took non-diagnostic, poor quality and/or substandard radiograph images for multiple patients. The images at issue were taken by Respondent in 2014 and 2015, prior to acquiring digital radiographic technology for his office. Tr., 9/27/19, pp. 15, 16. Respondent testified that digital radiographic technology produces better quality images, but in 2014 and 2015 when digital technology was still evolving, a preponderance of the evidence establishes that he engaged appropriate methods of radiographic imaging that resulted in diagnostic quality images within the standard of care. Tr., 9/27/19, pp. 21, 22. Dr. George Curry, who has over 37 years of experience working with radiograph images, agreed with Respondent and testified that the quality of radiograph images diminishes over time. Tr. 4/26/18, p. 48, 49; Tr. 6/6/19, pp. 9, 12; Tr., 9/27/19, p. 23. Despite the images presented in this matter being several years old, Dr. Steven Thiele and Dr. Curry both testified that all of the images taken by Respondent were of diagnostic quality, and the Board, based on its own expertise, agrees. Tr. 6/6/19, pp. 26-46; Tr. 11/1/18, pp., 15, 16, 19, 20, 23, 26, 30, 32, 33, 36, 37, 39. Dept. Exs. 8-12. Therefore, the evidence establishes that with the tools available to him at the time, Respondent met the standard of care and produced quality diagnostic radiographic images. Tr. 9/27/18, pp. 20-26, 32, 41, 43, 47, 52, 58, 61.

With respect to paragraph 2c of the Charges, the Board finds that a preponderance of the evidence fails to establish that Respondent failed to establish, document and/or use appropriate radiographic protocol. First, the evidence sufficiently establishes that Respondent properly documented his findings, as proven in the records submitted by the Department. Tr. 6/6/19, p. 46; Dept. Exs. 3-7.

Section 19a-14-10 of the Regulations of Connecticut State Agencies ("the Regulations") provides, in pertinent part, that:

> The purpose of a medical record is to provide a vehicle for: documenting actions taken in patient management; documenting patient progress; providing meaningful medical information to other practitioners should the patient transfer to a new provider or should the provider be unavailable for some reason. Dept. Ex. 13.

In this case, Respondent included all basic information in his records: patient's name, age, date, height, weight, vitals (if indicated), orthopedic testing, neurological testing, the history establishing the rationale for radiographic imaging, and his signature. Tr. 6/6/19, p. 46; Dept. Exs. 3-7. The information provided in Respondent's records adequately document his actions, patient progress, and provides meaningful medical information for other practitioners in compliance with § 19a-14-10 of the Regulations, and. therefore, meets the standard of care.

Next, the Board finds that Respondent used appropriate radiographic protocol in 2014 and 2015. In his practice, Respondent required patients to undress, take off their shoes, take off any jewelry and metal, and put on a gown. Tr. 9/27/19, pp. 20, 22, 23, 36. Women were not requested to remove their bras. Tr. 9/27/19, p. 23. Patients were taken into a room with a lead shielded door and four lead shielded walls. The x-ray bucky was in the rear of the room and the tube was on the right-hand side towards the wall pointing straight at the bucky. Tr., 9/27/19, pp. 18, 19. Patients are lined up with their right side against the bucky, and when they are turned facing the tube their left side is against the wall. The tube was positioned based on the necessary dimensions. Tr., 9/27/19, pp. 19, 20. The tube angle and positioning was adjusted to achieve better views. Tr., 9/27/19, p. 21. The Department presented radiograph images in which the outline of a woman's bra or a belt buckle could be seen. Dept. Ex. 9. Drs. Thiele and Curry both testified there is no violation of the standard of care if a chiropractor does not require women to remove their bras, nor does it constitute a deviation from the standard of care by a chiropractor if a patient fails to remove all metal objects after being instructed. Tr. 11/1/18, p. 13, 33-35; Tr. 6/6/19, pp. 24, 44. Moreover, they each testified that additional radiographs would not be required if the area of concern remains viewable. Tr. 11/1/18, p. 98; Tr. 6/6/19, pp. 24, 25. Therefore, the evidence establishes that Respondent engaged in an appropriate radiographic protocol for his patients in 2014 and 2015.

With respect to paragraph 2d of the Charges, the Board finds that a preponderance of the evidence fails to establish that Respondent used inappropriate radiographic technique guidelines by failing to identify whether the right or left side was imaged. Dr. Thiele testified that, "the

film blocker where films are flashed and the patient's information is provided, is always on the upper left side of the cassette. Tr. 11/1/18, pp. 18, 76-84. This is consistent with Respondent's testimony that he always has the patient label on the top left of the radiograph images based on placement of the patient's ID marker. Tr. 9/27/18, p. 65; Tr. 6/6/19, pp. 25, 37, 39, 40, 42, 45. Additionally, Respondent testified that prior to sending films to external offices, he always identifies the left and right side of the radiographic film as a practice. (Tr. 9/27/19, pp. 86, 120, 121). Respondent's practice of labeling and identifying the left and right side of his radiograph images is within the standard of care. Tr. 11/1/18, p. 79-81; Tr. 6/6/19, pp. 26, 46, 47,

With respect to paragraph 2e of the Charges, the Board finds that a preponderance of the evidence fails to establish that Respondent took radiographs using inadequate collimation resulting in unnecessary radiation exposure to multiple patients.[3] The Department's witness, Dr. Gregory, testified that the collimation on the films taken by Respondent was inappropriate. Whereas, Respondent's witnesses, Drs. Thiele and Curry both testified that the collimation on the films taken by Respondent was appropriate. Tr. 11/1/18, pp. 7, 8, 19, 25; 6/6/19, pp. 31, 34, 36, 39, 41, 42, 48. Despite a difference of opinions, experts for both parties referenced the Yochum and Rowe textbook used in chiropractic colleges, as the authority that provides that collimation to film size is the standard of care, (Tr. 11/9/17, pp. 86, 147; Tr. 6/6/19, pp. 48, 49). Collimation to film size is the standard of practice used by Respondent. Tr. 9/27/18, pp. 24, 25, 32, 37, 46. In this instance, however, the Board finds the testimony of Drs. Thiele and Curry to be more accurate and credible. Respondent utilizes the Gonstead technique in his practice, which uses specific measurements and landmarks to adjust the lines on the films. (Tr. 11/1/18, pp. 7, 8, 19, 25) Unlike Dr. Thiele's and Dr. Curry's testimonies, (Tr. 11/1/18, pp. 7, 8, 19, 25; 6/6/19, pp. 31, 34, 36, 39, 41-42, 48; Resp. Ex. 3), Dr. Gregory's testimony and report did not address the Gonstead technique. Tr. 11/9/17, pp. Tr. 4/26/18, pp. 4-189. Therefore, Dr. Gregory's testimony is deemed unreliable and inapplicable in methodology, and Respondent's collimation on the radiographs, as opined by Drs. Thiele and Curry, met the standard of care.

With respect to paragraph 2f of the Charges, the Board finds that a preponderance of the evidence fails to establish that Respondent took radiographs and failed to shield and/or properly shield multiple patients. Shielding is an attempt to limit exposure from an x-ray to a certain part

[3] Collimation is the shielding of the patient and narrowing of the x-ray beam to protect the patient. Tr., 11/9/17, pp. 68-69; Tr. 9/27/18, p. 90; Tr. 6/6/19, p. 25.

of the body. Tr. 6/6/19, p. 26. It was evident from the radiograph images presented that Respondent utilized breast and gonad shielding when necessary, and minimized x-ray exposure through collimation. Tr. 9/27/18, pp. 32, 38, 50, 84; Tr. 6/6/19, pp. 34, 36; Dept. Exs. 8-12. Shielding is not exact. It is an approximation to protect areas and can slide down. Tr. 6/6/19, p. 35. Respondent admits that in some instances the shielding was off in the images, but as testified by Dr. Curry, a new image is not required if the area of interest is not obstructed. Tr. 9/27/18, pp. 32, 33; 51; Tr. 6/6/19, p. 35. The shielding utilized by Respondent in 2014 and 2015, met the standard of chiropractic care. Tr. 6/6/19, p. 48.

With respect to paragraph 2g of the Charges, the Board finds that a preponderance of the evidence fails to establish that Respondent failed to maintain appropriate records. As provided in the Board's reasoning for paragraph 2c of the Charges above, Respondent included all basic information in his records, the rational for radiographic imaging, as well as a summary of his findings and signature in compliance with § 19a-14-10 of the Regulations. Tr. 6/6/19, pp. 48, 49; Dept. Exs. 3-7. The Board finds Respondent's records were clear and easy to follow, thereby meeting the standard of care. Dept. Exs. 3-7.

ORDER

Based upon the record in this case, the above findings of fact and the conclusions of law, the Charges against license number 001055 of Luigi DiRubba, D.C. are hereby DISMISSED.

April _____, 2020

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By: Gina M. Carucci, D.C., Acting Chairperson